11:42:56 a.m.

2 /22

	ROVIDER OR SUPPLIER	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		DING	(X3) DATE SURVEY COMPLETED	
COMMUN (X4) ID PREFIX	ROVIDER OR SUPPLIER	09G190	B. WIN		04/-	14/2010
PRÉFIX	ITY MULTI SERVICE	s, inc	1	STREET ADDRESS, CITY, STATE, ZIP O 1608 EVARTS ST, NE WASHINGTON, DC 20018		
	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL 9C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CO	N SHOULD BE E APPROPRIATE	COMPLETI DATE
W 000	INITIAL COMMENT	s	W 00	00	 	1 .
	13, 2010 through A initiated using the fu random sample of t a population of four	vey was conducted from April oril 14, 2010. The survey was indamental survey process. A wo clients was selected from male clients with various indation and disabilities.				:
W 104 4	observations at the program, Interviews review of clinical and including Incident re 183.41D(a)(1) GOVI	group was based on group home and one day with clients and staff and the dadministrative records ports. ERNING BODY must exercise general policy, og direction over the facility.	W 10	GOVERNMENT OF THE DISTR DEPARTMENT OF I HEALTH REGULATION AD 825 NORTH CAPITOL ST., I WASHINGTON, D.	RICT OF COLUMB HEALTH DMINISTRATION N.E., 2ND FLOOR	Į.
S E R a W	Surveyor: 18886 Based on observatio eviaw, the governin and ensure it's policy where stored under	not met as evidenced by: on, interview and record g body failed to implement y that all controlled substance double locks, for one of the in the facility. (Client #1, #2,				
C a o lo	i.m., the licensed probserved unlocking a ock on it. At 7:55 a.	on April 13, 2010, at 7:40 actical nurse (LPN) was a file cabinet that had one m., the LPN was observed m from the cabinet and				
PRATORY D		AUSUPPLIER REPRESENTATIVES SIGN	TURE	TOE		(X8) DATE
RU	stance (1. Keese Y	ran	an Duesto	5/1	2/11

11:43:15 a.m. 05-12-2010

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 04/28/2010 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A BUI		IPLE CONSTRUCTION IG :	(XS) DATE S COMPLI	URVEY
		09G190	B. Wil	1 G	<u> </u>	04/4	4/2010
NAME OF F	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	V-41	7/2010
COMMU	NITY MULTI SERVICE	S, INC		1	608 EVARTS ST, NE VASHINGTON, DC 20018		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	COMPLETION DATE
W 104	Interview with the Li approximately 8:20 administration rever indicated that control (Clonazepam) shouldocks. Review of the agent approximately 9:30 statement.	PN on April 13, 2010, at a.m., after the medication aled the agency's policy blied substances id be stored under double by policy on April 14, 2010, at a.m., confirmed the LPN's	W1	104	The Primary Nurse will ensure that a medications which are considered conedications will be stored under do A separate locked container was pure and placed in the locked medication	ontrolled uble locks. rchased	4/15/10
	integrated, coordinate qualified mental retardation profession that clients received evaluation, for one of the sample. (Client: The finding includes: On April 13, 2010, at observed receiving interview with the lice	coressional. Interestment program must be ted and monitored by a professional. In not met as evidenced by: In, staff interview and record ty's qualified mental anal (QMRP) failed to ensure the recommended GI fithe two clients included in #1)	W 1	50			
	supplement. Review of Client #1's 2010, beginning at 9.	administered as an iron medical record on April 13, 53 a.m., revealed a v consult dated June 15,					

11:43:31 a.m. 05-12-2010 4/22

DEPA	RTMENT OF HEALTH	AND HUMAN SERVICES				PRINTED	: 04/28/2010
CENT	ERS FOR MEDICARE	& MEDICAID SERVICES				FORM	APPROVED
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDENSUPPLIERCLIA IDENTIFICATION NUMBER:	4	IULTIPLE CONSTRUCTION		(X3) DATE S	
		09G190	B. WI	lG	_		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS OFF STREET		04/1	4/2010
COMM	UNITY MULTI SERVICE	<u> </u>		STREET ADDRESS, CITY, STATE, 1608 EVARTS ST, NE WASHINGTON, DC 20011			
(X4) ID PREFIX TAG	(EACH DEFICIENCY REGULATORY OR LE	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOU O THE APPR	H D RE	(XS) COMPLETION DATE
W 249	2009. The consult reliance that time, the hemai client needed a thore exclude GI blood loss review of the client's July 24, 2009, concurrecommendation. Interview with the Qiffer willing to sign medical interview indicated the sign for the aforement According to the QM maker would be explained for the thorout At the time of the surrensure that Client #1 consent to obtain a threcommended. 483.440(d)(1) PROGIMS 3.440(d)(1)	noted that the client had a iron deficiency amenia". At tologist recommended that the bugh GI evaluation, to as, as the etiology. Further medical assessment dated arred with the hematologist' MRP on April 13, 2010, at that Client #1's family in the clients habilitation and all consents. Further not the mother did not want to into ned procedure. RP, a medical decision ored to have a consent gh GI evaluation. vey, the QMRP falled to received the necessary norough GI evaluation, as RAM IMPLEMENTATION lisciplinary team has individual program plan, give a continuous active	W 24	Client #1 is scheduled for evaluation to exclude GI 2010. A consent form withe evaluation.	a thorough	n May 25.	5/25/10
	Surveyor: 18886	not met as evidenced by:				:	

11:43:48 a.m. 05-12-2010

CEN	I ERS FOR MEDICARI	H AND HUMAN SERVICES - E & MEDICAID SERVICES		;	PRINTE	D: 04/28/20 M APPROV)1(EE
SIATE	MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI	TIPLE CONSTRUCTION	OMB N	O. 0938-03	9
		09G190	B. WING				
	OF PROVIDER OR SUPPLIER MUNITY MULTI SERVICE			TREET ADDRESS, CITY, STATE, ZIP CODE 1608 EVARTS ST, NE WASHINGTON, DC 20018	04/	<u>/14/2010</u>	_
PREF TAG	REGULATORY OR L	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	~	(205) COMPLETIO	
W 24	review, the qualified professional (QMRF	I mental reterdation), failed to ensure continuous one of the two clients ble. (Client #1).	W 249				_
	During the entrance beginning at 9:35 a.r retardation profession Client #1 received or The support is provided behaviors by using a	conference on April 13, 2010, m., the qualified mental nai (QMRP) indicated that ne to one support services.		The QMRP and House Manager wall training programs within the IPP that each objective addresses Clientraining needs with appropriate documentation.	to ensure	5/ 31/10	
	assisted with his eath activities. Interview w staff on April 13, 2010	nout the survey, on April 13 lient #1 was being physically ng, drinking, and tabletop rith the one to one support 0, at approximately 7:00 e client refuses on most of rograms.					
W 255	program objective while apply lotion to his body on 80% of the trials record the individual program.	gust 12, 2009, on April 13, 72:00 p.m., revealed a ch stated, "[the client] will 7 with stand by assistance conded per month." Review im plan (IPP) on April 13, 12:45 p.m., revealed no ograms to address the	W 255				1
		plan must be reviewed at]		<u> </u> 		
M CMS-256	7(02-99) Previous Versions Ober				Ţ	1	

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/28/2010 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER (X3) DATE SURVEY A. BUILDING 09G190 B. WING NAME OF PROVIDER OR SUPPLIER 04/14/2010 STREET ADDRESS, CITY, STATE, ZIP CODE COMMUNITY MULTI SERVICES, INC 1608 EYARTS ST, NE WASHINGTON, DC 20018 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) PREFIX PROVIDER'S PLAN OF CORRECTION TAG (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 255 Continued From page 4 W 255 least by the qualified mental retardation The QMRP will ensure all IPP are revised as 5/31/10 professional and revised as necessary, including, needed when the client successfully completes but not limited to situations in which the client has an objective. Client #1's IPP will be revised successfully completed an objective or objectives due to the fact he has accomplished his identified in the individual program plan. objective. This STANDARD is not met as evidenced by: Surveyor: 18888 Based on observations, staff interviews and record review, the facility's qualified mental retardation professional (QMRP) failed to review and revise the Individual Program Plan (IPP) once the client had successfully completed an objective identified in the IPP for one of the two clients in the sample. (Client #2) The finding includes: Observations on April 13, 2010, at 6:30 p.m., revealed direct care staff carrying a laundry basket to Client #2's bedroom. Interview with the staff, at 6:50 p.m., Indicated that the client participates in a washing program and requires verbal prompts. Review of Client #2's IPP dated February 22, 2010, revealed a program objective which stated, "[the client]" will improve his independent living skills by being able to wash his clothes with minimal physical assistance, three days a week in 100% of trials." Review of the data sheets, on April 14, 2010, at approximataly 11:45 p.m., from December 2009 through March 2010, revealed the client required verbal prompts to independent 100% of the trials recorded. There was no evidence that the QMRP revised the program (wash his clothes).

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTE	RIMENT OF HEALTH ERS FOR MEDICARE	AND HUMAN SERVICES MEDICAID SERVICES				PRINTED): 04/28/2010 ! APPROVED
ISTATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				OMB NO	. 0938-039
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BL		TIPLE CONSTRUCTION	(X3) DATE 8 COMPL	
		09G190	B. W	ING		1	
NAME OF	PROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE	04/1	4/2010
COMML	JNITY MULTI SERVICE	58, INC		1	1808 EVARTS ST, NE WASHINGTON, DC 20018		
(X4) ID PREFIX TAG	I LEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAC	-IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	Mode	(XS) COMPLETION DATE
W 325	482.460(a)(3)(iii) Ph	YSICIAN SERVICES	10/	226	DEFICIENCY)		·
	The facility must pro examinations of each includes routine some	ovide or obtain annual physical	W.;	325	The Primary Nurse, QMRP, and Hou Manager will review medical records #2 weekly to ensure that they receive necessary laboratory testing recommendation the primary care physician.	for Client e the	5/14/10
	Based on staff intervine facility's nursing a laboratory testing as primary care physicis	not met as evidenced by: iew and record verification, staff failed to provide routine determined necessary by the an (PCP), for two of the two e sample. (Clients #1 and					
ĺ	The findings include:					l I	
	Cilent #1's medical re beginning at 9:53 a.m dated from March 20(complete laboratory s Tegretol levels, Compwith differential, Prolatevels evels every six month	at 7:43 a.m., Client #1 was segretol 200 mg. Review of cord on April 13, 2010,, revealed physician's order 20, through April 2010, to tudies for the following: blets Blood Count (CBC) ctin levels, and Platelets as. Further review revealed re completed on July 21,					
1	2:30 p.m., respective	stered nurse (RN) on April 2010, at 10:00 e.m., and ly confirmed that the not been completed as					
2	. Review of Cilent#2 4, 2010, beginning at	's medical record on April 11:00 a.m., revealed					

11:44:38 a.m. 05-12-2010 8 /22

DEPAR	TMENT OF HEALTH	I AND HUMAN SERVICES			PRINTE): 04/28/2 01(
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM	<i>II Approved</i>
AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII	ULTIPLE CONSTRUCTION DING	(X3) DATE S), 0938-0391 SURVEY ETED
		09G190	8. WIN	G	<u> </u>	
NAME OF	PRDVIDER DR SUPPLIER			CTIVETT ASSOCIATION OF THE STATE OF THE STAT	04/1	4/2010
	NITY MULTI SERVICE	·		STREET ADDRESS, CITY, STATE, ZIP CODE 1608 EVARTS ST, NE WASHINGTON, DC 20018		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECT	4 # C CE	(XS) COMPLETION DATE
W 325	Continued From pag	je 6	W 32			1
 	prolactin levels even revealed no evidence interview with the rep 14, 2010, at 12:30 p.	gistered nurse (RN) on April	VV 31			
W 371	ordered. 483.480(k)(4) DRUG The system for drug that clients are taugh medications if the intidetermines that self-s	not been completed as ADMINISTRATION administration must assure t to administer their own ardisciplinary team administration of medications active, and if the physician	W 37	The primary care nurse will complete proper documentation of self-adminimedications for Client #1 and Client the self-medication readiness assess be updated as needed.	stration of #2, and	5/14/1 0
T 1 an Nh	Sased on observation eview, the facility falk system to ensure each elf-medication prograticuled in the sample in the findings include: Observation of the dministration on April evealed Client #1 was redications by the facilities (LPN). The LPN is client's medication of client's medication.	13. 2010, at 7:43 a.m., administered his illity's Licensed Practical N was observed to punch a from their bubble packs.				

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/28/2010 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (XX) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (23) DATE SURVEY COMPLETED A. BUILDING B. WING 09G190 04/14/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE COMMUNITY MULTI SERVICES, INC 1608 EVARTS ST, NE WASHINGTON, DC 20018 (X4) ID PREFIX **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 371 Continued From page 7 W 371 interview with the LPN, after the medication pass. revealed the client did not participate in a self-medication training program. Review of the record on April 13, 2010, at 2:27 p.m., revealed a self medication assessment dated November 26. 2009. The assessment indicated that the client was assessed at Skill Level II, which required, "staff assistance/semi-independent" in the area of self-administration of medication. The assessment, however, did not indicate whether or not she was a candidate for self-medication training. Review of Client #1's Individual Program Plan (IPP) dated August 4, 2009, on April 13, 2010, at approximately 3:00 p.m., revealed no program goal or objective for the client to receive training in self-medication skills development. 2. Observation of the morning medication administration on April 13, 2010, at 8:00 a.m., the LPN was observed punching Client #2 medications from the bubble pack into a cup. pouring a cup of water and handing both cups to the client. The client consumed the pills and water independently. interview with the LPN, after the medication pass. revealed the client did not participate in a self-medication training program. Review of the record on April 14, 2010, at 1:00 p.m., revealed a self medication assessment dated November 26. 2009. The assessment indicated that the client was assessed at Skill Level iI, which required, "staff assistance/semi-independent" in the area of

FORM CMS-2567(02-99) Previous Versions Obsolete

self-administration of medication. The

assessment, however, did not indicate whether or not he was a candidate for self-medication

Event ID:5X4Q11

Facility ID: 09G190

If continuation sheet Page 8 of 10

DEPA	RTMENT OF HEALTH	HAND HUMAN SERVICES			DDMITTE	D. 5485554
CENT	ERS FOR MEDICARE	E & MEDICAID SERVICES			FOR	D: 04/28/2010 M APPROVED
I STATEM	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			OMB N	0.0938-0391
AND PLAI	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M A. BUR	ULTIPLE CONSTRUCTION LDING	(X3) DATE	
}		09G190	B. WIN	G	1	
NAME OF	PROVIDER OR SUPPLIER	090190			04/	14/2010
i			1	STREET ADORESS, CITY, STATE, ZIP CODE		
COMM	UNITY MULTI SERVICE	is, inc	- 1	1608 EVARTS ST, NE		
W41 15	Ol hers A market			WASHINGTON, DC 20018		
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TAG	REGULATURY OR LI	SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	III fa Ge	COMPLETION DATE
W 37	Continued From page	ge 8	W 3	74		
	training.		44.3	α_{\parallel} .		
				İ		i 1
	Review of Client #2"	s Individual Program Plan				1
	(IPP) dated Februar	V 22, 2009, na Andi 14, 2046, i				! }
	at approximately 1:3	0 p.m., revealed no program		!		1 1
	in self-medication sk	the client to receive training				!
W 381	483.460(I)(1) DRUG	STORAGE AND	101			1
	RECORDKEEPING	O O O O O O O O O O O O O O O O O O O	W 38	Cross reference W104		4/15/10
						4/18/10
	The facility must store conditions of security	re drugs under proper				
	Based on observation verification, the facility ensure that controlled under double locks, for residing in the facility. The finding includes: On April 13, 2010, at practical nurse (LPN) file cabinet that had on the LPN was observe from the cabinet and a interview with the LPN approximately 8:20 a. administration reveale indicated that controlled.	7:40 a.m., the licensed was observed unlocking a ne lock on it. At 7:55 a.m., ad retrieving Clonazepam administering it to Client #2.				•
	Review of the agency is approximately 9:30 a.n	policy on April 14, 2010, at	į			

11:45:27 a.m. 05-12-2010 11 /22

AND PLAN (T OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE), 0938-039 SURVEY	
			A. BUILDIN	lG	COMPL	ETED	
		09G190	B. WING_		041	140040	
	ROVIDER OR SUPPLIER NITY MULTI SERVICE	S, INC	1	REET ADDRESS, CITY, STATE, ZIP COD 608 EVARTS ST, NE VASHINGTON, DC 20018	04/14/2010		
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W 381	Continued From pa statement.	ge 9	W 381				
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Event ID:5X4Q11

Facility ID: 09G190

if continuation sheet Page 10 of 10

Health i	Regulation Administra	ation			•	PRINTE FORM	D: 04/28/2010 APPROVED
	YT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU HFD03-0200	ER/CLIA IMBER:	(X2) MU A. BUILL B. WING		(X3) DATE COMP	
NAME OF	PROVIDER OR SUPPLIER	111003-0200	STREET AD	Deces cit	Y, STATE, ZIP CODE	04/	14/2010
	NITY MULTI SERVICE	8, INC	1608 EVA	ARTS ST, I STON, DC	NE .		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	E191	ID PREFIX TAG	PRDVIDERS PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	liin ne	(XG) COMPLETE DATE
	Surveyor: 18886 A licensure survey v 2010, through April of two residents was of four male resident mental retardation a The findings of the sobservations at the program, interviews the review of clinical including incident representations and sanitary manner accumulations of dirtodors. This Statute is not m Surveyor: 18886 Based on observation Mentally Retarded (Ginterior of the GHMR) orderly, attractive, and the four residents in (Residents #1, #2, #3) The findings include: An environmental insignation of the direction of the gradients and the four residents in (Residents #1, #2, #3) The findings include: An environmental insignation of the direction of the gradients #1, #2, #3 The findings include: An environmental insignation of the direction of the gradients #1, #2, #3 The findings include:	vas conducted from 14, 2010. A random is selected from a points with various levels and disabilities. Survey was based on group home and one with residents and a and administrative reports. PING sample pulation s of day taff and records citive, lionable for the a clean, or four f.	1090	Light bulbs will be replaced in the or light fixture.	verhead	5/14/10	
t	hree of the four builds	out,	iiev				
With Regulat	ion Administration	V	t	er la	7 ^	i	
by block i	MRECTOR'S OR PROVIDER	OSURPLIER REPRESENTA	TIVE'S SIGNA	TURE /	MAN Vireita	0 5	G) DATE
ATE FORM					X4Q41	If continuation	nheet 1 of 10

Health	Regulation Administr	ation				FORM	APPROVED
STATEM AND PLA	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM HFD03-0200	R/CLIA MBER:	(X2) MUI A. BURLD B. WING		(X3) DATE SURVEY COMPLETED	
NAME OF	PROVIDER OR SUPPLIER	111-10-03-0200	STREET A	DDDEES CITY	, STATE, ZIP CODE	04/	14/2010
ľ	UNITY MULTI SERVICE	ES, INC	1608 EV	ARTS ST, N GTON, DC	E		
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109	Continued From pa	ige 1		I 090			
	cabinets had food of outside of them. 3. Two pots and/or	ins stored under the li lebris and grease on pans had broken hai	the		Pots and pans will be thoroughly vand cleaned daily. QMRP/ Manager inspect weekly.	will	4/15/10
RO 1	them. 3504.6 HOUSEKEE				New pots and pans will be purcha replace ones with broken handles.	sed to	5/20/10
	 Each poison and ca	ustic agent shall be s d shall be out of direc	tored in t reach	1095			
	Surveyor: 18886 Based on observation Home for Mentally Refailed to store poisor locked cabinet and/oresident, for four of the facility. (Resident The finding includes:	its #1, #2, #3 and #4) :	-iMRP) in a of each iding in		The QMRP and House Manager will deliy to ensure that all caustic agents atored in a locked cabinet at all times	are .	4/14/10
	During the environm 2010, at beginning a (i.e., spray cleaner a observed being store unsecured caustic agine qualified mental (QMRP) on the same environmental walk-t	t 2:30 p.m., caustic and bathroom cleanen ed in an upstairs close gents were confirmed tetardation profession e day, during the	gents s) were et. The				
i 161	3507.2 POLICIES AN	approved by the gove	ming	1 161			
elih Basa	body of the GHMRP	alio squii de reviewed	at			: 1	

_ Health	Requiation Administra	ation				PRINTE FORM	D: 04/28/2010 II APPROVED
STATEM	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	ER/CLIA MBER:	PC2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE	SURVEY LETED
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NAME OF	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE			
COMM	UNITY MULTI SERVICE	S, INC	1608 EV	ARTS ST, I GTON, DC	1E		
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l 181	least annually.	met as evidenced by and record review, the ovide evidence that the reved and reviewed are annually. It is a lifted mental retards and review of the poor April 13, 2010, at a evidence that the priewed and approver	ation oficy and 1:00 bolicy	J 181	The QMRP will send the Policy and F Menual to the Main Office to be revie signed by the Program Director annu	wed and	5/31/10
	a508.5(c) ADMINIST Each GHMRP shall he that shows the following of the categories and and direct care staff; and an and direct care staff; and an analysis of the Group Hornanual, the Group Hornanual, the Group Hornanual, the Group Hornanual, the Group Hornanual chart direction of supportive the finding includes: Review of the GHMRF on April 13, 2010, beg	tave an organization ing: Id numbers of supposend et as evidenced by: It policy and proceduome for the Mentally HMRP) failed to prove policy categories a search direct care state.	rtive ares ride an and	1 186	The Program Director will ravise CMS' Organization Chart to Include categorithe number of supportive and direct ca	es end	5/31/10

Health	Regulation Administra	ation				FORM	APPROVED
STATEME AND PLAN	INT OF DEFICIENCIES N DF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU HFD03-0200	R/CLIA MBER:	()C2) MUI A. BUILD B. WING		(X3) DATE &	SURVEY ETED
NAME OF	PROVIDER OR SUPPLIER	NF003-0200	RTDEET A	ADDRESS, CITY, STATE, ZIP CODE			4/2010
	UNITY MULTI SERVICE	S, INC	1608 EV	ARTS ST, A GTON, DC	Æ		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY DR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDERS PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)		(X6) COMPLETE DATE	
1 186	Continued From pa	ge 3	· · · · · · · · · · · · · · · · · · ·	1186			<u> </u>
	that the organization categories and num care staff.	n chart failed to list the	le nd direct				
1 206	3509.6 PERSONNE			1 206	The QMRP and House Manager w	ill request	5/31/10
	Each employee, prior to employment and annually thereafter, shall provide a physician 's certification that a health inventory has been performed and that the employee 's health status would allow him or her to perform the required duties.			current health certificates from dire aids, nursing staff, and consultants records will be reviewed quarterly f health certificates.	. Personnel		
	This Statute is not in Surveyor: 18886 Based on interview a Home for the Mentali (GHMRP) falled to el consultant had a cui five of the ten staff, tone of the eleven cor	and record review, the last record review, the last record review, the last record rec	e for		·		
	The finding includes: Interview with the que professional (QMRP) records on April 14, 2 approximately 2:30 p. falled to provide evide certificates were on fil (Staff #1, #2, #3, #5 a nurses (nurse #1, #2, the eleven consultant	alified mental retards and review of the per colon, beginning at .m., revealed the GH ence that current heale, for five of the ten and #7), two of the series, #4 and #5) and colons.	MRP ith staff ven				
1 227	3510.5(d) STAFF TRA	AINING		1227			
Jih Reculet	100 Administration						

Health Regulation Administration FORM APPR							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0200		ER/CLIA MBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED		
NAME OF	PROVIDER OR SUPPLIER	HPD03-0200	STREET AL	DOBERS AND	, STATE, ZIP CODE	04/1	4/2010
	INITY MULTI SERVICE	8, INC	1608 EV/	ARTS ST, N GTON, DC	E		
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1 227	Continued From pag	ge 4		1 227			<u> </u>
	Each training program shall include, but not be limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans;			1221	The QMRP and House Manager will that all direct care aids and nursing a working within the group home have CPR and first aid training.	staff	5/31/10
	This Statute is not met as evidenced by: Surveyor: 18888 Based on record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to have on file for review, current training in cardiopulmonary resuscitation (CPR), for two of the ten staff and one of the seven nurses, and current training in first aid, for three of the ten staff and five of the seven nurses.						
i	The finding includes:		Į.	•			
	Review of the person April 14, 2010, beging the GHMRP failed to staff training in CPR, #4 and #5) and one o #2), and current training the ten staff (Staff #2, seven nurses (Nurse)	ning at 2:30 p.m., re provide documentati for two of the ten sta if the seven nurses (ing in first aid, for the . #3. and #4) and five	vealed ion of iff (Staff Nurse ee of			 - - - - -	
1 422 3521.3 HABILITATION AND TRAINING			1 422				
6	Each GHMRP shall po and assistance to resi the resident's Individ	idents in accordance	with				
į	This Statute is not me Surveyor: 18888 Based on observation, eview, the Group Hon	. Interview and recor	d				

_Health	Regulation Administra	ation		_		FORM	APPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0200		ER/CLIA MBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED			
NAMEO	PROVIDER OR SUPPLIER	111 000-0200	SIDEET AF	DDEBE CIT	STATE, ZIP CODE	04/	/14/2010	
COMMINETY MILL TO SERVICES INC. 1608 EVA			ARTS ST, A GTON, DC	E				
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142	2 Continued From pa	ge 5		1422			!	
	Retarded Persons (GHMRP) falled to ensure habilitation, training and assistance were provided to its residents in accordance with their individual Habilitation Plan(s), for one of the two residents included in the sample. (Resident #1)			,	Cross reference W249		5/31/10	
	The finding includes	3:						
	During the entrance confarence on April 13, 2010, beginning at 9:35 a.m., the qualified mental retardation professional (QMRP) indicated that Resident #1 received one to one support services. The support was provided to decrease the resident's behaviors by using, appropriate/positive procedures and assist with activities of daily living skills.					·		
	Observations throughout the survey, on April 13 -14, 2010, revealed Resident #1 was being physically assisted with his eating, drinking and table top activities. Interview with the one to one support staff on April 13, 2010, at approximately 7:00 p.m., indicated that the resident refused on most of his daily living skills programs.							
	Review of Resident #1's Occupational Therapy assessment dated August 12, 2009, on April 13, 2010, at approximately 2:00 p.m., revealed a program objective which stated, "[the resident] will apply lotion to his body with stand by assistance on 80% of the trials recorded per month." Review of the Individual program plan (IPP) on April 13, 2010, at approximately 2:45 p.m., revealed no evidence of training programs to address the resident's training needs.							
l 424	3521.5(a) HABILITAT Each GHMRP shall n resident's program a	nake modifications to	the	1 424				

Health F	Regulation Administra	ation			FORM	IAPPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0200		(A2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED			
NAME OF F	PROVIDER OR SUPPLIER	111 000-0200	STREET AD	DRESS CITY	, STATE, ZIP CODE	04/1	4/2010
COMMUNITY MUI TI REDVICER UPO 1608 EVA			NRTS ST, N STON, DC	E			
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424	Continued From page	ge 6		1424			
	or when the client:				Cross reference W255		5/31/10
	(a) Has successfully completed an objective or objectives identified in the Individual Habilitation Plan; This Statute is not met as evidenced by: Surveyor: 18886 Based on staff interviews and record review, the Group Home for the Mantally Retarded Persons (GHMRP's) Qualified Mental Retardation Professional (QMRP) failed to review and revise the Individual Program Plan (IPP) once the resident had successfully completed an objective identified in the IPP, for one of the two residents included in the sample. (Resident #2) The finding includes: Observations on April 13, 2010, at 6:30 p.m., direct care staff was observed carrying a laundry basket to Resident #2's bedroom. Interview with the staff, at 6:50 p.m., indicated that the resident participates in a washing program and requires verbal prompts.						
	Review of Resident: 2010, revealed a pro "[the resident]" will in skills by being able to minimal physical ass 100% of trials." Revi April 14, 2010, at app December 2009 through resident required independent 100% of the resident was no evident he program (wash him.	gram objective which approve his independent wash his clothes wistance, three days also of the data sheet proximately 11:45 p.r. ugh March 2010, reviverbal prompts to fithe trials recorded.	n stated, ent fiving ith week in s, on n., from ealed				

Health F	Regulation Administra	ation				FORM	APPROVED
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1 436	Continued From pa	ge 7		1438			!
! 436	3521.7(f) HABILITA	••	10	1			i l
				1436	Cross reference W371		5/14/10
	The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas:					0/14/10	
	(f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety);						
	This Statute is not met as evidenced by: Surveyor: 18886 Based on observations, interviews and the review of records, the Group Home for Mentally Retarded Persons (GHMRP) failed to implement an effective system to ensure that each resident participated in a self-medication training program, for two of the two residents in the sample. (Residents #1 and #2)						
1.	The findings include:					j	
	1. Observation of the administration on Apprevealed Realdent #1 medications by the fall Nurse (LPN). The LF the resident's medications when the resident's medication of the resident's rand physically spoon his medications.	ril 13. 2010, at 7:43 at mas administered had little and massed Pracelling to the second to the servation revealed the medication with another second to the	i.m., is ctical punch ble ne LPN		·		
n : s : n s	nterview with the LPI evealed that Resider lelf-medication trainfr scord on April 13, 20 lelf medication asses 1009. The assessme	nt #1 did not participa ng program. Review 10, at 2:27 p.m., revi sment dated Novem	of the			.	

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER COMPLETED A. BUILDING B. WING HFD03-0200 04/14/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1608 EVARTS ST, NE COMMUNITY MULTI SERVICES, INC WASHINGTON, DC 20018 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 1436 | Continued From page 7 1436 1 436; 3521,7(f) HABILITATION AND TRAINING 1436 The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (f) Health care (including skills related to nutrition. use and self-administration of medication, first ald, care and use of prosthetic and orthotic devices, preventive health care, and safety); This Statute is not met as evidenced by: Surveyor: 18886 Based on observations, interviews and the review of records, the Group Home for Mentally Retarded Persons (GHMRP) failed to implement an effective system to ensure that each resident participated in a self-medication training program, for two of the two residents in the sample. (Residente #1 and #2) The findings include: 1. Observation of the morning medication administration on April 13, 2010, at 7:43 a.m., revealed Resident #1 was administered his medications by the facility's Licensed Practical Nurse (LPN). The LPN was observed to punch the resident's medications from their bubble packs. Continued observation revealed the LPN mixed the resident's medication with applesauce and physically spoon fed/administered the client his medications. interview with the LPN, after the medication pass, revealed that Resident #1 dld not participate in a self-medication training program. Review of the record on April 13, 2010, at 2:27 p.m., revealed a self medication assessment dated November 26, 2009. The assessment indicated that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0260		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE COMP	(X3) DATE SURVEY COMPLETED	
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	required, "staff assi- the area of self-adm assessment, however not she was a candi- training. Review of Resident	sed at Skill Level II, vistance/semi-independinistration of medicater, did not indicate widate for self-medicater, did not indicate widate for self-medicater, 2009, on April 13, p.m., revealed no prothe resident to receive the resident to receive the medication skills developed the morning medication and 13, 2010, at 8:00 and 14, after the medication the pills and water with the pills and water with the pills and water the medicater that the pills and water the medicater that the pills and water the pills and participater that the pills and	dent" In tion. The thether or tion am Plan 2010, at togram ye ment. n. m., the elega cup sident. ar of the realed a liber 26, sich ent" in on. The ether or in on. The ether or in plan 1, 2010, togram	1 438	DEFICIENCY			

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1 484	Continued From pa	ge 9	, ,,	1484			
1 484	3522.11 MEDICATI	ONS .		1 484			1 1
	REGULATORY OR LSC IDENTIFYING INFORMATION)			The Primary Care Nurse, QMRP, a Manager will check all topical medical weekly to ensure that they are not cand the labels are legible.	cations	5/12/10	